PATIENT FORM

Name: _____ Date: _____

Did a physician refer you to us today? ☐ Physician: Dr. _____ at _____

How did you hear about us? ☐ Magazine/Newspaper ☐ Website ☐ Yellow Pages ☐ Family/Friend

Explain your symptoms in detail for seeing the doctor today: *(i.e. lower back pain, headaches, etc.)*

_____

_____

_____

When did this symptom first begin? Very first time: _____ Last time: _____

What event caused your symptoms? *(if known)*

_____

OTHER SYMPTOMS:

	YES	NO
Frequent headaches	☐	☐
Vision problems (besides eyeglasses)	☐	☐
Hearing problems	☐	☐
Chest pain	☐	☐
Breathing problems	☐	☐
Vomiting	☐	☐
Numbness	☐	☐
Urination difficulties:		
– Starting urine	☐	☐
– Losing urine	☐	☐
Bleeding problems (clotting)	☐	☐
Dizziness	☐	☐
Balance problems	☐	☐
Weakness in extremities: R L	☐	☐

Others (List)

_____

_____

ALLERGIES: LIST ALL DRUG ALLERGIES (ALSO NOTE IF ALLERGIC TO SHRIMP OR IVP DYE)

☐ No known allergies *(please check box)*

_____

_____

PLEASE ANSWER ALL QUESTIONS COMPLETELY. DO NOT LEAVE ANYTHING BLANK.

Are you presently taking any blood-thinning medications (i.e. Coumadin, Plavix, aspirin, or aspirin products)?
☐ Yes – If yes, please list below ☐ No

_____

Have you been diagnosed with any autoimmune diseases? *(i.e. Lupus, rheumatoid arthritis, etc.)*
☐ Yes – If yes, please list below ☐ No

_____

Are you currently taking any immune suppressant drugs?
☐ Yes – If yes, please list below ☐ No

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

DRUG	STRENGTH	TIMES A DAY

LIST ALL SURGERIES	YEAR

ILLNESS:

	YES	NO
High blood pressure	☐	☐
Heart problems	☐	☐
Diabetes	☐	☐
Kidney disease	☐	☐

PLEASE LIST ALL OTHER PAST/PRESENT MEDICAL CONDITIONS:

_____

_____

_____

_____

_____

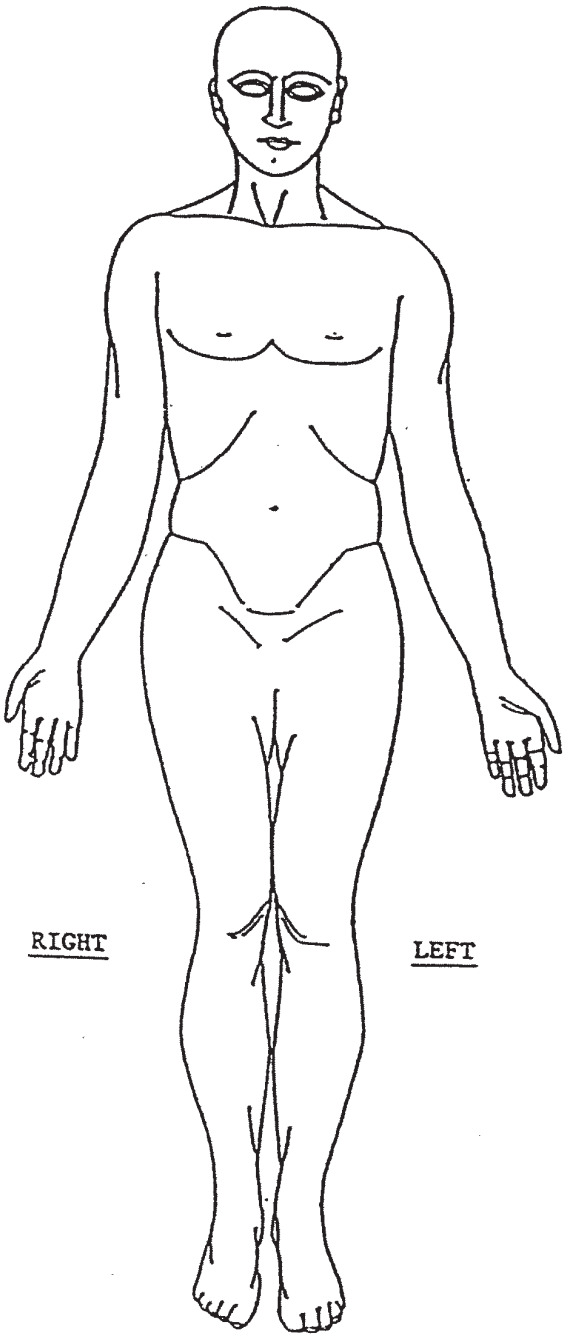
Thomas A. Staner, MD

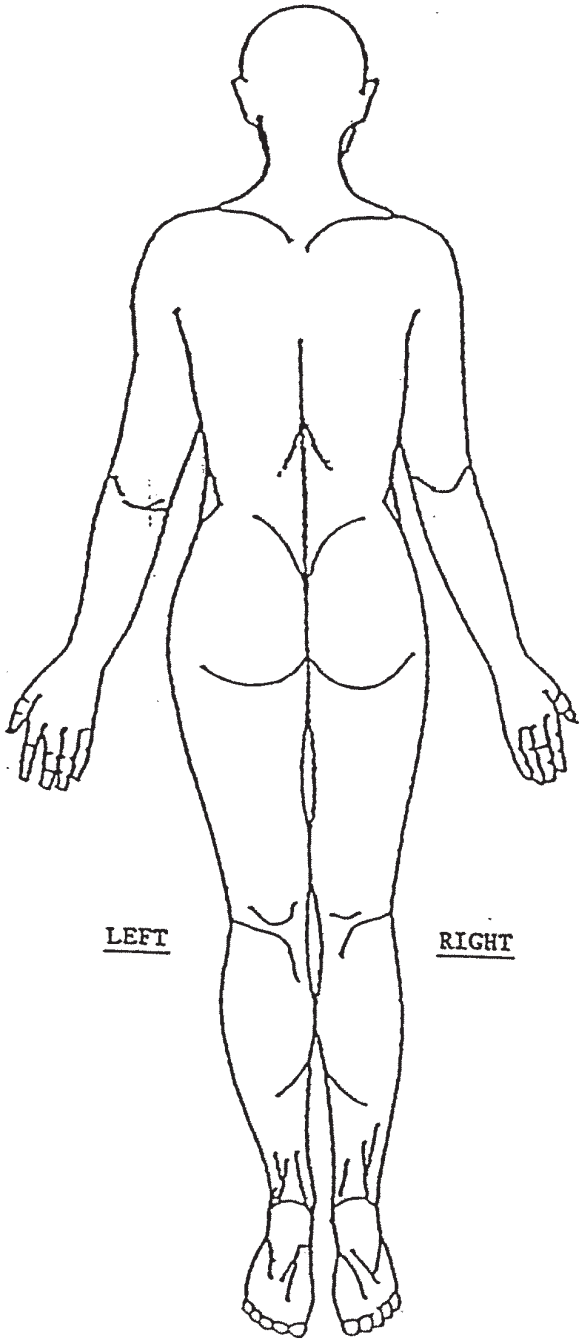
Name: _____

On the scale below, circle your pain level, with “0” being no pain at all and “10” being the worst pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

PLEASE SHADE IN AREA(S) OF PAIN





Name: _____ Date: _____

PLEASE ASSIST US WITH SPECIFICS:

Have you been treated for this condition by another physician? ☐ Yes ☐ No

If so, which physician(s), and list ALL types of treatments, including DATES:

_____

_____

_____

_____

_____

Have you been on anti-inflammatory medications within the past 3 months? ☐ Yes ☐ No

If so, how long? _____ and name of medication _____

Have you had physical therapy for this condition within the past 3 months? ☐ Yes ☐ No

Have you had epidural blocks for this condition? ☐ Yes ☐ No

If so, how many? _____ Date of last block _____

Who did the blocks?_____

Where were the blocks done? _____

FAMILY HISTORY: PLEASE INDICATE MATERNAL/PARENTAL GRANDPARENTS, MOM, DAD, AUNTS, UNCLES, ETC.

Spinal problems ☐ Yes ☐ No If yes, describe: _____

Bleeding disorders ☐ Yes ☐ No If yes, describe: _____

Heart disease ☐ Yes ☐ No If yes, describe: _____

Cancer (type) ☐ Yes ☐ No If yes, describe: _____

Diabetes ☐ Yes ☐ No If yes, describe: _____

Kidney disease ☐ Yes ☐ No If yes, describe: _____

Lung disease ☐ Yes ☐ No If yes, describe: _____

SOCIAL HISTORY:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Remarried ☐ Widowed ☐ Separated

Work status: ☐ Working ☐ Not Working ☐ Student ☐ Retired

☐ Disabled *(reason):* _____

Primary occupation: _____ Employer: _____

If not working, last date worked: _____

Do you smoke/dip/chew tobacco products? ☐ Yes ☐ No Amount/day: _____ # Years: _____

If quit, when? _____

Alcohol use: ☐ Yes ☐ No # beers/drinks per day: _____ # beers/drinks per week: _____

Have you used: Marijuana: ☐ Yes ☐ No Cocaine: ☐ Yes ☐ No Heroin : ☐ Yes ☐ No

Other:_____

Last time you used: _____ Any addiction problems: ☐ Yes ☐ No